STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155252	A. BUILDING 01 B. WING	02/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-WOODLANDS	4088 FRAME RD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/04/13 Facility Number: 000155 Provider Number: 155252 AIM Number: 100266830 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Golden Living Center-Woodlands was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping	K0000	*Preparation and submission of this Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	rooms. The facility has a capacity of 114 and had a census of 108 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except three detached structures; one plastic shed, one wood framed shed, and one wood framed garage with vinyl siding used for facility storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/13/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 2 sets of dining room double doors to the corridor were equipped with positive latches and latched into their door frames. This deficient practice could affect up to 92 residents, staff, and visitors while in the main dining room. Findings include: Based on observation on 02/04/13 at 1:38 p.m. during a tour of the facility with the Maintenance Director, the two sets of double doors from the dining room to the corridor did not latch into their door frames. Furthermore, the dining room was not provided with smoke detection. This was acknowledged by the	K0018	**K 018** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:**Corrective action taken consisted of contacting TriState Fire Protection Services to hard wire 6 smoke detectors in the main dining room. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:**All residents affected equally. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:**TriState Fire Protection	03/06/2013

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	Maintenance Director at the time of observation. 3.1-19(b)		Services hard wired 6 smoke detectors in the main dining room. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:**No further corrective action or monitoring required once smoke detectors are installed. **Systemic changes will be completed by 3/6/13**	

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K0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen service metal rolling doors was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect up to 92 residents as well as staff and visitors while in the main dining room. Findings include: Based on observation on 02/04/13 at 1:45 p.m. during a tour of the facility with the Maintenance Director, the metal rolling service door between the kitchen and dining room was held open with a chain and fusible link which would not allow the door to close automatically when the fire alarm system is actuated. Based on	K0021	**K 021** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Construction company contacted to review and enclose window with solid construction eliminating window. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** All residents affected equally. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:** Window to kitchen was sealed	03/06/2013

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	interview at the time of observation, the Maintenance Director acknowledged the metal roller door between the kitchen and dining room was held open with a chain and fusible link which would not allow the door to close automatically when the fire alarm system was actuated. 3.1-19(b)		with solid construction. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** No further corrective action required once window is eliminated. **Systemic changes will be completed by 3/6/13**	

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K0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
	1. Based on observation and interview, the facility failed to ensure 2 of 9 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect 9 residents, as well as staff and visitors in the 200 hall. Findings include: Based on observations on 2/04/13 between 11:30 a.m. and 2:30 p.m. during a tour of the facility with the Maintenance Director, the smoke barrier wall above the drop ceiling at the 200 west smoke barrier doors had a ten inch gap through the wall next to the sprinkler pipe, furthermore, the smoke barrier wall above the 200 hall east smoke barrier doors had three penetrations through the wall which were not fire stopped. The penetrations were around two conduits and one sprinkler pipe ranging in size from one half inch to one inch. This was acknowledged by the	K0025	**K 025** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Corrective action consisted of all small penetrations being sealed with fire barrier seal caulking. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** No other residents affected. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:** Maintenance department to inspect all area walls on completion of any subcontracted job to ensure no break of the smoke barriers. If any areas are	03/06/2013

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	Maintenance Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 12 residents, as well as visitors and staff in the 600 hall. Findings include: Based on observation on 02/04/13 at 12:05 p.m. during a tour of the facility with the Maintenance Director, the 600 hall Janitor's Closet had a one and a half foot section of ceiling drywall which had been replaced with new drywall. The new drywall was not finished which left a half inch gap one foot long open to the attic. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		discovered, they will be sealed with fire barrier seal caulking. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** Maintenance will report any deficient practice to executive director who will report in QA monthly X 6 months unless further monitoring is deemed necessary at that time. **Systemic changes will be completed by 3/6/13**	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure 3 of 3 access doors to the courtyard which were equipped with delayed egress locks were provided with signs stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. 7.2.1.6.1,says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process	K0038	**K 038** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Corrective action included placing order for the "Push until door sounds,, door can be opened in 15 seconds" and "No Exit" signs. Maintenance request completed for ACU keypad repair, gates to be trimmed to swing freely, and one gate hinge changes in order to swing in path of egress. Requested bids for sidewalk to extend around eastside of building to reach a public way. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** All residents could be affected. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:** Signs posted on all 3 doors indicating "Push until alarm	03/06/2013

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	shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect up to 10 residents, as well as staff and visitors while in the courtyard. Findings include: Based on observations on 02/04/13 between 11:30 a.m. and 2:30 p.m. during a tour of the facility with the Maintenance Director, all three doors to the courtyard were equipped with delayed egress locks and were not provided with signs		sounds door can be opened in 15 seconds" and "No Exit" sign posted on the 2 doors to the courtyard with no further corrective action required. ACU keypad to the outside gate repaired and will be checked for proper functioning weekly and documented for proper function weekly. Both gates in ACU courtyard were trimmed to allow the gates to swing freely. One gate repaired with hinges reconnected to allow gate to swing in the path of egress. No further corrective action required. Bids obtained for sidewalk to extend around building but must wait until weather breaks for installation. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** Maintenance will report functioning of the ACU gate keypads to the executive director who will report in QA monthly X 6 months unless further reporting is deemed necessary at that time. **Systemic changes will be completed by 3/6/13**. An extension is requested for installation of the sidewalk weather allowing, to be completed with in 90days.	

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	indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 3 doors to the courtyard were provided with signs indicating "NO EXIT". 7.10.8.1 requires any door, passage, or stairway that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. Such sign shall have the word NO in letters 2 inches high with a stroke width of 3/8 inch and the word EXIT in letters 1 inch high, with the word EXIT below the word NO. This deficient practice could affect any of the 92 residents outside of the Alzheimer's Care Unit, as well as staff and visitors while using the front lobby or the west sitting area. Findings include: Based on observations on 02/04/13 between 11:30 a.m. and 2:30 p.m. during a tour of the facility with the Maintenance Director, the door from the west sitting			

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	room to the courtyard and the door from the front lobby to the courtyard were not provided with signs stating "NO EXIT". This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 2 exterior gates from the Alzheimer's Care Unit (ACU) fenced in area, which was provided with an access controlled egress door/gate with a locking device connected to the fire alarm system, automatically unlocked when the fire alarm system was actuated. LSC Section 19.2.1 refers to LSC Chapter 7. LSC 7.2.1.6.2(d) requires activation of the building fire protection signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire protective signaling system has been manually reset. LSC 19.2.2.2.5 states doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only			

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	one such locking device shall be permitted on each door. This deficient practice could affect up to 16 residents, as well as staff and visitors in the ACU. Findings include: Based on observation on 02/04/13 at 12:50 p.m. during a tour of the facility with the Maintenance Director, the east gate of the ACU fenced in area was equipped with an access controlled egress locking device. This gate did not release from the magnetic locking device when the five digit code was pushed by the Maintenance Director and Certified Nursing Assistant (CNA) # 1, however, the gate did release from the magnetic locking device when the fire alarm system was actuated at 2:00 p.m. The Maintenance Director stated it must be the keypad that was not functioning correctly. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of 2 exterior gates from the Alzheimer's Care Unit (ACU) fenced in area, swung in the direction of egress travel. LSC 7.2.1.4.3 states a door shall swing in the direction of egress travel. Furthermore, the facility failed to ensure 2 of 2 exterior gates from			

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	the ACU fenced in area required no more than 15 pounds of force to open. LSC 7.2.1.4.5 states forces required to fully open any door manually in a means of egress shall not exceed 15 lbf to open the door to the minimum required width. This deficient practice could affect up to 16 residents, as well as staff and visitors in the ACU. Findings include: Based on observation on 02/04/13 between 12:50 p.m. and 1:05 p.m. during a tour of the facility with the Maintenance Director, the northwest gate of the ACU fenced in area swung into the fenced in area instead of swinging in the direction of egress to the parking lot outside the gate, furthermore, both gates required great force to open only half way because the bottom of each wooden gate dragged on the concrete sidewalk. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b) 5. Based on observation and interview, the facility failed to ensure not more than one delayed egress locking device was provided in 3 of 10 egress paths. NFPA 101 7.2.1.6.1 states approved, listed, delayed egress locks shall be permitted to			

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	be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system, or an approved, supervised automatic sprinkler system. NFPA 101, 19.2.2.2.4 Exception No. 2 requires delayed egress locks complying with 7.2.1.6.1 shall be permitted, provided not more than one such device is located in any egress path. This deficient practice could affect up to 46 residents, as well as staff and visitors from the 300, 500, and 600 halls. Findings include: Based on observations on 02/04/13 between 2:10 p.m. and 2:20 p.m. during a tour of the facility with the Maintenance Director, the exit doors from the 300, 500, and 600 halls were equipped with delayed egress locks. To reach a public way from these exits required traversing a connecting sidewalk on the south side of the facility, heading to the west through the two wooden gates of the Alzheimer's Care Unit which were both equipped with delayed egress locking devices. There was no sidewalk from the 500 hall exit to the east side of the facility to a public way. There was a 200 foot grassy area to the east side parking lot. This was acknowledged by the Maintenance			

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	Director at the time of observations. 3.1-19(b)			

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K0046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review, interview and observation; the facility failed to ensure the documentation for the testing of 3 of 3 battery powered light sets was complete when testing monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the Life Safety Code Documentation Binder on 02/04/13 at	K0046	**K 046** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** All battery back up light sets within the facility will be removed **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** No other residents affected **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:** All battery back up light sets within the facility will be removed **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** No further corrective action required once the lights are removed. The building is on 100% generator back-No further corrective action or monitoring	03/06/2013

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	10:30 a.m. with the Maintenance Director present, there was documentation to show the three battery back up light sets in the facility had been tested monthly for thirty seconds and a ninety minute annual test within the past twelve months, however, it was a blanket statement each month which did not include an itemized list of each battery back up light set. Based on observation during a tour of the facility, all three battery back up light sets did function properly. This was confirmed by the Maintenance Director at the time of record review. 3-1.19(b)		necessary. **Systemic changes will be completed by 3/6/13**	

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K0050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Fire Drills on 02/04/13 at 11:05 a.m. with the Maintenance Director present, three of four second shift (evening) fire drills conducted since February of 2012 were performed between 3:12 p.m. and 4:10 p.m., furthermore, all four third shift (night) fire drills held since February of 2012 were performed between 4:37 a.m. and 5:15 a.m. During an interview at the time of record review, the Maintenance Director acknowledged the times of the second and third shift fire drills were not varied.	K0050	**K 050** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Reviewed varying times of fire drills for each shift with maintenance director. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** All residents affected equally. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:** Maintenance department to hold a minimum of 1 fire drill per shift per quarter at varied times through out the shift. A different shift to host the fire drill each	03/06/2013

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	3-1.19(b)		month. Executive director/designee will review building engines program monthly for completion and varied times of fire drills. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** Maintenance director to report to executive director the fire drill in service held each month with staff which will be reported in QA X 6 months unless further monitoring is deemed necessary at that time. **Systemic changes will be completed by 3/6/13**	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 6 areas outside and attached to the building and constructed partially of combustible material. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice could affect up to 10 residents, staff and visitors while using courtyard. Findings include: Based on observation on 02/04/13 at 1:55 p.m. during a tour of the facility with the Maintenance Director, there was a ten foot by seven foot canvas canopy attached to the building in the courtyard from the west sitting room door. There was no	K0056	**K 056** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Reviewed with maintenance, canopy will be detached from building. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** All residents using the courtyard could be affected. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:**	03/06/2013

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	sprinkler coverage provided under the canopy. Based on interview at the time of observation, the Maintenance Director said there was no documentation available to show the canopy was flame retardant and also acknowledged there was no sprinkler coverage under the canopy. 3.1-19(b)		Canopy will be detached from the building. No further corrective action required. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** No further corrective action required once canopy is detached from the building. **Systemic changes will be completed by 3/16/13**	

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K0062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure 5 of over 500 sprinkler heads in the facility were free of paint. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint. Any sprinkler shall be replaced that is painted. This deficient practice could affect any of the 9 residents, as well as staff and visitors while in the 200 hall and Laundry area. Findings include: Based on observations on 02/04/13 between 11:30 a.m. and 2:30 p.m. during a tour of the facility with the Maintenance Director, the sprinkler head in resident room 207 was partially covered with paint, furthermore, four of five sprinkler heads in the laundry room were partially covered with paint and dust or lint. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b)	K0062	**K 062** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Tri State Fire Protection contacted for review and repair of the fire sprinkler heads. Sprinkler heads noted to be painted were replaced. Maintenance ensured sprinkler heads were free of dust and lint additional spare replacement heads ordered. Wires wrapped around the sprinkler pipe on the ACU was removed and pipe hanger installed. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** All residents have the potential to be affected equally. **The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:**	03/06/2013

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	2. Based on observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler head storage cabinets were provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observations on 02/04/13 between 11:30 a.m. and 2:30 p.m. during a tour of the facility with the Maintenance Director, the two spare sprinkler head cabinets in the facility had six spare sprinkler heads each, but, only included one side wall sprinkler head and no quick response pendent type sprinkler heads. The remaining sprinkler heads were a mixture of other pendent type sprinkler heads and upright type sprinkler heads. Sidewall sprinkler heads and quick response sprinkler heads were observed in the facility during the tour. This was acknowledged by the Maintenance Director at the time of observation, furthermore, the Maintenance Director indicated there were no other spare		Tri State Fire Protection replaced sprinkler heads with any noted paint. Maintenance has cleaned the laundry sprinkler heads free of dust and lint. Fire sprinkler heads in laundry will be monitored monthly for dust and lint by maintenance. Maintenance will inspect any areas of painting by outside contractors to ensure sprinkler heads have no noted paint. Any sprinklers found with paint will be cleaned or replaced. Maintenance has purchased additional sprinkler heads and will have a minimum of at least 2 spares for each type of sprinkler head at all times. Supply will be reviewed monthly with preventative maintenance program. Metal wires were removed from sprinkler piping and pipe hanger was installed with no other corrective action required. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** Maintenance will report findings and trends to the executive director who will report in QA monthly X6 months unless further monitoring is deemed necessary at that time. **Systemic changes will be completed by 3/6/13**	

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	sprinkler heads in the facility. 3-1.19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 2 automatic sprinkler systems was continuously maintained. NFPA 25, 2-2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect up to 62 residents, as well as staff and visitors in the west unit of the facility. Findings include: Based on observation on 02/04/13 at 12:45 p.m. during a tour of the facility with the Maintenance Director, there were two metal wires wrapped around a three inch sprinkler pipe as well as a gas pipe above in the Alzheimer's Care Unit Mechanical Room. At the time of observation it was unclear whether the gas pipe was supporting the sprinkler pipe with the wire, or the wire was wrapped around the sprinkler pipe for another reason. Based on interview at the time of observation, the Maintenance Director said he was not aware of the wire wrapped around the sprinkler pipe but would find out why it was there and have it removed.			

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K0074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure 1 of 4 sprinklered shower rooms were provided with 18 inches of clearance from the ceiling to the bottom of the cubicle curtain mesh for sprinklers to be effective. NFPA 13, Table 4-6.5.1.2 requires the distance above an obstruction for pendant or upright sprinklers to be 18 inches if the obstruction is five feet or more from the sprinkler. This deficient practice could affect 1 resident at a time, plus staff in the 400 hall shower room. Findings include: Based on observation on 02/04/13 at	K0074	**K 074** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Shower curtains with mesh extended to the ceiling have been ordered. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** 93 residents have the potential to be affected.	03/06/2013

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	11:45 a.m. during a tour of the facility with the Maintenance Director, the 400 hall shower room had two cubicle curtains with no mesh that extended to the ceiling. When the cubicle curtains were closed there would be no sprinkler coverage in that area of the shower room. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		**The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:** Shower curtains were replaced with cubicle curtains with mesh that extends to the ceiling. No other corrective action required. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** No further corrective action required once the cubicle curtains are replaced. **Systemic changes will be completed by 3/6/13**	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transferring takes place was provided with at least a 1 hour fire resistive constructed ceiling. This deficient practice could affect up to 92 residents, as well as staff and visitors in the 100 through 600 halls during time spent in the dining room which was in the same smoke barrier as the oxygen storage/transfer room. Findings include: Based on observation on 02/04/13 at 1:30 p.m. during a tour of the facility with the Maintenance Director, the oxygen storage/transfer room had four liquid oxygen tanks stored inside. The room	K0143	**K 143** **The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:** Construction company notified to review oxygen storage room for installation of additional ceiling. **Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:** No other residents affected. **The measures put into place and the systemic changes made to ensure that this deficient practice does not**	03/06/2013

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	was provided with only a single layer of five eights inch drywall on the ceiling which did not meet the one hour fire resistance rating. The Maintenance Director confirmed this room was used for oxygen storage and oxygen transferring at the time of observation. 3.1-19(b)		**recur are as follows:** Additional Ceiling installed in oxygen room to provide at least a 1 hour fire resistive rating. No further corrective action required. **These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** No further corrective action required. **Systemic changes will be completed by 3/6/13**	